Tennessee Department of Health
Newborn Hearing Screening Program
Maternal and Child Health, Newborn Screening
Cordell Hull Building 4th Floor MCH, 425 5th Avenue North, Nashville, Tennessee 37243
1-855-202-1357 615-532-8462 Fax 615-532-8555

Report of Infant Hearing Re-Screen or Diagnostic Evaluation

Child's Last Name | First Name | Middle Name | Sex | Birth Date

Mother's Last Name | First Name | Mother's Maiden Name | State Lab TDH# (if available)

Address | City | State/Zip | Phone

Referred by: ☐ Hospital Screening ☐ pass ☐ refer Name of Hospital_____

☐ Other_____

Primary Care Provider:_____

Date of Evaluation: _____ ☐ **Initial Screen** ☐ **Re-Screen** ☐ **Diagnostic** ☐ **Risk F/U**

Risk Indicators for Hearing Loss: _____

Type(s) of Evaluation: ☐ AABR/ABR ☐ OAE ☐ TEOAE ☐ DPOAE ☐ ASSR ☐ Tymp ☐ Behavioral Testing

Degree of Hearing Loss:		**Ear**	
Screen Only:	Pass/Refer	☐ R	Pass/Refer ☐ L
Hearing Within Normal Limits		☐ R	☐ L
Slight	(16-25 dB HL)	☐ R	☐ L
Mild	(26-40 dB HL)	☐ R	☐ L
Moderate	(41-55 dB HL)	☐ R	☐ L
Moderately Severe	(56 -70 dB HL)	☐ R	☐ L
Severe	(71-90 dB HL)	☐ R	☐ L
Profound	(91+ dB HL)	☐ R	☐ L
Sloping Hearing Loss		☐ R	☐ L

Type of Hearing Loss:	**Ear**	
Fluctuating Conductive HL	☐ R	☐ L
Permanent Conductive HL	☐ R	☐ L
Sensorineural Hearing Loss	☐ R	☐ L
Auditory Neuropathy/Dyssynchrony	☐ R	☐ L
Mixed Hearing Loss	☐ R	☐ L
Unspecified Hearing Loss	☐ R	☐ L

Other Information _____

_____

Inconclusive due to: _____

Referrals:	**Date**		
☐ No Referral	_____	☐ Children's Special Services (CSS)	_____
☐ Repeat Hearing Testing	_____	☐ Speech/Language Services	_____
☐ Primary Care Provider (PCP)	_____	☐ Hearing Aid Fitting	_____
☐ Medical Specialist (ENT/OTO)	_____	☐ Genetic Referral	_____
☐ Early Intervention Program	_____	☐ Family Support/Family Voices	_____
☐ TEIS ☐ Other _____		☐ Vision Referral	_____
		☐ Other _____	

Follow-up date: _____ **Comments:** _____

_____

Provider: _____ **Phone: (____)_____**

Audiologist, Medical Provider, Hospital, Early Intervention Provider, Other

Address: _____

City: _____ **State/Zip:**_____

Mail to above address or **Fax to 615-532-8555** Attn: Newborn Hearing Coordinator Rev. Jan2012 PH-3684